Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-15-0768-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Work Compensation claim are to be reimbursed 125% of the Medicare allowable. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 2nd quarter 2014, E0217 RR is supposed to be reimbursed at $60.44 per unit x 125%."

Amount in Dispute: $458.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier, New Hampshire Insurance Company is maintaining their position that the additional $458.65 requested by the requestor, Universal DME LLC for the service provided on 5/1/2014 is not owed to the requestor, Dallas Medical Center/Universal DME LLC."

Response submitted by; AIG Services, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1 – 7, 2014	E0218 RR	$458.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Labor Code §413.011 sets forth general provision related to reimbursement policies and guidelines.
4.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P5 – Based on payer reasonable and customary fees. No maximum allowable. Defined by legislated fee arrangement
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

Issues

1. Is there an established fee schedule amount for services in dispute?
2. What is applicable rule pertaining to fair and reasonable?
3. Did the requestor support request for additional reimbursement?
4. Is the requestor entitled to reimbursement?

Findings

1. Texas Administrative Code §134.202 states, in pertinent part "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   Review of the submitted documentation finds HCPCS code E0218 – RR was submitted on claim line.

   Per Noridian Health Care Solutions, Medicare Pricing Data Analysis and Coding (PDAC), https://www.dmepdac.com/dmecsapp/do/hcpcsdetail?hcpcs_base_id=16036206, E0218 – "Water circulating cold pad with pump." "This code does not appear on the CMS National Fee Schedules available in DMECS."

   Texas Administrative Code §134.202 (c) states, "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS;". The service in dispute will be reviewed per applicable Texas Medicaid Fee Schedule for the date of service in dispute. The Texas Medicaid allowable, http://public.tmhp.com/FeeSchedules/OnlineFeeLookup/FeeScheduleSearchResults.aspx is $50.59 for the date of service in dispute. This amount multiplied by 125% = (50.59 x 125%) or $63.24.

2. The total allowable for the services in dispute is $63.24. The carrier previously paid $70.20. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.